



BURLINGTON
AREA SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT

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Physical Examination

Student's Name: _____ Birthdate: _____

Address: _____ School: _____ Grade: _____

Parent / Guardian Name: _____ Phone: _____

| | Normal | Abnormal | Referral | Not Evaluated | |
|----------------------------|--------|----------|----------|---------------|--------------|
| General Appearance | () | () | () | () | |
| Posture, Gait | () | () | () | () | |
| Speech | () | () | () | () | |
| Head | () | () | () | () | Ht: _____ |
| Skin | () | () | () | () | |
| Eyes, External Aspects | () | () | () | () | Wt: _____ |
| Ears, External Aspects | () | () | () | () | |
| Ears, Internal Aspects | () | () | () | () | B/P: _____ |
| Nose, Mouth, Pharynx | () | () | () | () | |
| Teeth | () | () | () | () | Pulse: _____ |
| Heart | () | () | () | () | |
| Lungs | () | () | () | () | Resp: _____ |
| Abdomen (include hernia) | () | () | () | () | |
| Bones, Joints, Muscles | () | () | () | () | |
| Neurological / Social | () | () | () | () | |
| Gross Motor | () | () | () | () | |
| Fine Motor | () | () | () | () | |
| Glands (lymphatic/thyroid) | () | () | () | () | |
| Muscular Coordination | () | () | () | () | |

Allergies (Be Specific): _____

Current Medications: _____

Acute / Chronic Conditions: (Diabetes / Asthma / Etc..) _____

Immunizations Given Today: ()DTP ()Polio ()Hib ()MMR ()Varicella 1 - 2 ()HBV 1 - 2 - 3 ()Other _____
() Up-to-date (please attach record)

Restrictions / Recommendations: _____

Physician Signature: _____ Date: _____

Physician Address: _____ Phone No: _____